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TQM Is Alive but Not as We Know It: The Use of a Novel TQM Model in a Private Healthcare Company

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Abstract

UK healthcare has been facing an unprecedented quality crisis in recent times. In this context, the author setout to develop and evaluate the use of a novel total quality management (TQM) model in a private healthcare firm with the aim of improving patient care. By integrating contemporary organizational theories with TQM, an innovative model called EALIM—ethical, adaptive, learning and improvement model—was devised. Using an action research study, qualitative data were gathered in three research cycles, (1) pre-implementation, (2) implementation, and (3) post-implementation. Initial results showed EALIM's adoption generated a moral organizational perception among employees, increased organizational commitment, emergence of a learning culture, and improvements in patient self-advocacy and independence. However, other findings indicated poor leadership produced variability in service quality. Although outcomes from this study clearly indicated that EALIM generated organizational improvement, commitment from all internal stakeholders is required to achieve sustainable quality patient care.

Keywords: TQM, quality improvement, healthcare, corporate social responsibility, organizational complexity, knowledge management

1. Introduction

Providing quality goods and services to satisfy customer needs has been a long-term strategic goal for both manufacturing and service organizations. Indeed, it may be argued that it is due to the basic fundamentals of quality policies and principles that organizations are successfully competing in an ever-growing antagonistic marketplace [1]. Whether it is an automobile recall, a failed medical operation or a poorly performing school, the consequences of poor quality underscore the significance of quality management. A particular quality management approach that emerged in the latter part of the twentieth century was total quality management (TQM). Though many descriptions of TQM exist, it can be defined as "Total—everyone associated with

the company is involved, Quality—customers' expressed and implied requirements are fully met, and Management—executives are fully committed [2]." However, unlike its many definitions, little disagreement exists among authors on TQM's key principles, which include top management leadership, customer focus, continuous process improvement, employee education and participation, statistical reporting, as well as recognition and reward.

Largely spawned by the success of TQM in reversing Japan's broken post war economy, during the 1980s and 1990s a global TQM revolution emerged. Consequently, many western companies adopted TQM principles into their corporate strategies to boost competitiveness and financial performance. However, by the early 1990s, empirical investigations began to emerge, asserting that most TQM efforts failed to produce desired results, including TQM initiatives in healthcare. By the late 1990s, critics had grown, claiming TQM had lost its dominance, emphasizing the need to focus on more contemporary management approaches [3–5]. Although various authors have attributed TQM failures to implementation issues, others have been more critical, pointing to theoretical limitations. Nonetheless, a number of scholars commonly agree that the underlying reason for TQM's decline was its incompatibility with a postmodern organizational context [6, 7]. This point suggests TQM requires reform to become a contemporary management approach, fit for the 21st century.

Over the last 10 years, UK healthcare has been encountering an unprecedented quality crisis, especially considering the overwhelming challenge of improving patient care in the face of growing demands and budget constraints. These bottlenecks gave rise to research the development of an innovative and sustainable TQM model that could yield quality patient care. The target organization used to conduct the research was a private healthcare provider, offering specialist services to adults with learning disabilities and mental health disorders in London and the Home Counties.

This chapter draws upon that five-year research in two main parts:

The first part deals with the conceptual development of the model, which began by reviewing the literature to identify the theoretical and implementation issues of TQM. These findings were then used to inform the selection of contemporary organizational theories for integration with TQM that could ameliorate the issues identified. Following this process, three contemporary organizational theories were selected:

- corporate social responsibility (CSR),

- complexity theory (CT) and

- knowledge management (KM).

The reasons for choosing these, along with their distinct advantages and conceptual links with TQM, are stated. For the purpose of this study and within this context, organizational theory is defined as a body of thinking that conceptualizes organizational phenomena based on specific principles and assumptions [8]. By integrating these three organizational theories with TQM, a novel model called EALIM—ethical, adaptive, learning and improvement model—was devised, an acronym that captures the nexus of each theory. The ethical part of the model relates to the integration of CSR, the adaptive part to CT, the learning part to KM and the

improvement part relates to TQM. This part of the chapter ends by presenting the main principles of EALIM, along with its methods that link to each of its theories, forming a coherent conceptual framework.

The second part of this chapter provides a research overview of EALIM's implementation within the target organization. An action research (AR) methodology was chosen, since it holds features congruent with the author's professional practice and the participatory context of implementing the model. A qualitative strategy of gathering data was used as this seemed best suited for understanding contextual factors and explaining the internal logic of human action in response to interventions. Data gathering methods included depth interviews, participant observation and focus groups, which fall within the scope of qualitative research. Data were gathered over an 18-month period in three AR cycles. In the first cycle, data were collected to form a baseline assessment of the firm.

In the second cycle, a collaborative action plan was developed and EALIM's implementation was examined. In the third cycle, further data were accumulated and findings were evaluated against the baseline assessment to identify EALIM's overall impact.

Although other authors [9, 10] have conceptually developed healthcare-specific TQM models, a dearth of research exists with regards to the implementation and evaluation of such models. It follows that the research presented in this chapter addresses this paucity. Moreover, since no other conceptual framework fully integrates corporate social responsibility, complexity theory and knowledge management within TQM, EALIM can be relied upon as an original contribution to TQM theory. In essence, EALIM presents a broadening conception of TQM that could yield better results, since it is more suited to a postmodern organizational context.

2. Theory building and model development

The research began with a qualitative review of the organizational literature to identify key issues with TQM theory and implementation in manufacturing and service industries. The initial search located about 400 studies. However, after a narrative review, only 41 were selected for analysis because the other studies did not adequately critically review TQM. Thematic analysis was then applied to the selected studies, using open, axial and selective coding. This coding involved comparing the textual accounts of each study to identify codes, forge connections between codes, and organize them into meaningful thematic categories [11]. Results from this analysis are depicted in two tables. The first is **Table 1**, which describes seven commonly reported TQM implementation barriers.

Although some studies found the use of TQM had yielded increased levels of product quality and organizational performance, most studies reported mixed results or high failure rates caused by implementation issues. For example, while Joss's study of TQM initiatives in UK healthcare reported some success in improving teamwork, these initiatives failed to make a direct improvement in service quality because of implementation obstacles like the lack of top management commitment and a disregard of cultural factors [12]. Barriers like these, not only give insights about why TQM efforts were disbanded,

Barrier 1	Lack of top management commitment and ethics
Description	TQM message is incongruous with the behavior of management. Conflict between the espoused message of TQM and its practice. Lack of visible participation by top management.
Barrier 2	Limited stakeholder approach from top managers
Description	Emphasis on customers and suppliers at the expense of other stakeholders. Managers fail to recognize their organizational responsibilities to society. Insufficient employee participation.
Barrier 3	Lack of adaptability to change and unintended outcomes
Description	Lack of spontaneity to unpredictable events. Slow response to changing customer requirements creates market drift. A controlling culture inhibits staff from adapting to dynamic customer needs.
Barrier 4	Too much emphasis on hard TQM factors
Description	Too much focus on the technical and analytical aspects of TQM. Statistical process control (SPC) is inadequate for evaluating metaphysical attributes like attitudes and motivation, warmth, care, etc.
Barrier 5	Disregard for contextual factors
Description	Top managers hold taken for granted assumptions about controlling culture. TQM dogma and framework is applied as a universal approach without adapting it to fit the organizational context.
Barrier 6	Middle management resistance
Description	Middle managers lack involvement and place too much reliance on a quality manager or department. TQM is perceived as a political threat to their authority.
Barrier 7	Inadequate learning
Description	Lack of a learning culture. Failure to apply knowledge in practice. No reflexive learning. Managers fail to learn how their leadership methods and actions contribute to implementation problems.

Table 1. Key TQM implementation barriers in manufacturing and service firms.

but also highlight differences between the rhetoric and reality of TQM adoption. Even in cases where TQM had succeeded, studies show this was after a 5-year implementation period, far too long for executives who require more immediate results [13]. Hence, for achieving sustainable TQM success, the newly developed model ought to address all the implementation barriers identified.

From the studies that problematized TQM theory, nine TQM theoretical limitations were identified, as depicted in **Table 2**. Most of these studies took a postmodern approach of making explicit TQM theory's unstated philosophical assumptions. For instance, Boje and Winsor argue that TQM methods are designed as social and psychologically engineered tools to efficiently extract maximum output from labor resource [6]. From this view, TQM is predicated on theoretical assumptions of scientific management, i.e., Taylorism—an approach that tends to disregard employees' emotional and psychological needs. Other limitations like TQM's managerial obsession with statistical process control reveal a technocratic ideology that treats workers akin to machine parts, at the expense of employee discretion and dignity [7]. These sorts of theoretical limitations lead to the conclusion that TQM is incongruous to a postmodern age of pluralism, uncertainty, organizational interdependence, employee knowledge and autonomy, because it emerged from an era of modernism where the emphasis was on labor resource efficiency and managerialism. This change in emphasis underscores the need to adapt TQM to fit within a postmodern organizational milieu. As previously discussed, the approach toward achieving this is to integrate more contemporary organizational theories with TQM that can address its theoretical and implementation issues.

Limitation 1	Investment and consumer capitalism
Description	Limited to serving shareholder interests and customer needs. Fails to adequately address the quality of experience of other stakeholders.
Limitation 2	Formal rationality
Description	Simple means-ends calculation using rules and laws. Lacks regard for the personal qualities of individuals and the impact decisions have on their wellbeing.
Limitation 3	Utilitarian rationality
Description	The efficient use of resources to achieve maximum output. Disregards employees' emotional and psychological needs, consequently harming quality efforts.
Limitation 4	Executive vision
Description	A vision constructed and imposed by executives. Reinforces control and undermines collaboration.
Limitation 5	Technocratic ideology
Description	Emphasizes following technical processes and systems. Removes employee discretion from work processes, treating them akin to machine parts.
Limitation 6	Single loop learning
Description	Restricts learning to means-end relationships. Occludes new ways of thinking and learning.
Limitation 7	Newtonian paradigm
Description	A linear and reductionist worldview. Cannot work in disequilibrium where cause/effect is non-linear.
Limitation 8	Codified and explicit knowledge sharing
Description	Reliant on the systematic sharing of express information. Occludes knowledge sharing that is informal and context dependent.
Limitation 9	External customer focus
Description	Emphasizes satisfying consumers. Lacks regard toward other key stakeholders.

Table 2. TQM's theoretical limitations.

The process of selecting contemporary organizational theories for integration with TQM, involved a broad review of the organizational literature. Qualitative methods of analysis were deployed as purported by Golden-Biddle and Locke [14], which included constructing inter-textual coherence (i.e., focusing on key contributions and forging connections between concepts), and problematizing the literature (i.e., identifying key issues that have not been addressed and presenting arguments for alternative perspectives). From the 20 or so organizational theories examined, three were selected based on the following criteria: (1) their fit with a postmodern context, (2) their potential to overcome TQM's theoretical limitations and implementation barriers, and (3) their conceptual links with TQM. This criterion was chosen because it would enable the expansion of TQM with organizational theories better suited to current contexts, while redressing the barriers and limitations previously identified. A description of each theory, reasons for selecting them, and their fit with TQM, are given in the next three subheadings. The number assigned to each finding from **Tables 1** and **2** have been included in parenthesis, to systematically account for how these theories redress TQM's shortcomings.

2.1. Corporate social responsibility (CSR)

By adopting concepts like stakeholder management, employee welfare, philanthropy and ecological sustainability, CSR can be defined as an organizational approach that demonstrates ethical regard for people, society and the planet [15]. Unlike CSR, TQM theory neglects the

importance of corporate philanthropy and ecological sustainability because its key premises are based on creating value for shareholders and meeting customer expectations. It follows that integrating CSR with TQM would enable a shared vision among a wider range of stakeholders. This approach could address TQM theory's prevalence on investment and consumer capitalism [Limitation 1], its restriction to an executive vision [Limitation 4], and its confined external customer focus [Limitation 9]. Since CSR involves a stakeholder approach, its integration could also overcome TQM's implementation issue of a limited stakeholder approach from top managers [Barrier 2]. Therefore, by conflating the instrumental activity of TQM and the ethics of CSR, a moral form of capitalism can be achieved, linking the success of the organization to the prosperity of its environment.

As noble as CSR sounds, it has been criticized for ignoring the wellness of employees. Lay-offs, long working hours, work–family conflict and inequality, are often overlooked in both the CSR and TQM literature [16]. To address these shortcomings, a CSR approach that includes socially responsible business practices on employee wellbeing should be adopted. This type of CSR approach denotes a Kantian duty ethic, where people are treated as both the means and the end [17]: a more humane rationality than TQM theory's utilitarian rationality [Limitation 3].

The adoption of a Kantian CSR approach can result in several outcomes: namely, it can enable managers and workers to understand their jobs are not merely a means for generating shareholder wealth, promote a sense of pride in the organization, and create awareness that their work is producing a far greater end for the human race, resulting in opportunities for commitment and action. These outcomes have the potential to redress two particular TQM implementation issues: lack of top management commitment and ethics [Barrier 1], and middle management resistance [Barrier 6].

2.1.1. CSR's fit with TQM

Although distinct differences exist between CSR and TQM, some mutual conceptual links have been identified, making their integration possible. For instance, while Ahmed and Machold argue that CSR's moral philosophy is incompatible with quality models that use rational economic principles [18], McAdam and Leonard contend TQM's focus on quality has affinity with CSR, since both are founded on respect for employees and customers [15]. Moreover, CSR principles like employee empowerment, responsibility and collaboration also have affinity with TQM, indicating that TQM can exist in a symbiotic relationship with CSR. It follows that TQM could provide a strong foundation in which to embed CSR values, since they share the common principle of "doing the right things right [19]." Finally, by coalescing the two theories, a more substantive rationality can be realized, a point that redresses TQM's formal rationality [Limitation 2], which tends to overlook the impact decisions have on people's wellbeing.

2.2. Complexity theory (CT)

Proponents of CT generally regard it as a body of concepts explaining the dynamic interaction of interdependent variables and how these generate bifurcation at the edge of chaos (i.e., disequilibrium), leading to unpredictability and emergence [20]. In organizations, its use has been focused on conceptualizing how local human interactions produce organizational,

societal and global patterns that are paradoxically linear and non-linear, predictable and unpredictable, for developing new ways of thinking about how organizations cope with conditions of uncertainty.

Various authors [21–23] have argued that because TQM was largely designed through a Newtonian paradigm of reductionism, objectivism and linear causality [Limitation 7], it fails in its contingency toward chaos, unpredictability and non-linear events of major change. It follows that a CT approach could overcome TQM's Newtonian limitations and foster new decision-making capabilities, an advantage particularly useful when organizations are subject to dynamic conditions. Since the lack of adaptability to change has been a common TQM implementation issue [Barrier 3], adopting a CT perspective could also enable organizational members to better adapt and self-organize in an environment of disequilibrium.

Although a number of complexity theories are presented in the literature, a complex responsive process theory was selected because it regards a corporate social ethic as a durable quality [24], which fits well with CSR. This may also be justified that unlike other complexity authors who adopt a mechanistic system view of organizations, Stacey predicates his view on communicative interaction among people: a humane ideology that addresses TQM's technocratic ideology [Limitation 5].

2.2.1. CT's fit with TQM

Although TQM's Newtonian and linear concepts have paradigmatic differences with CT's ideology of non-linear causality and unpredictability, some links can be made between the two. Dooley *et al*. have argued that TQM factors such as collaboration and empowerment have affinity with CT, in terms of encouraging emergence and self-organization [21]. For example, collaboration allows divergent and emergent thinking on the alternative routes individuals can take at bifurcation points, and empowerment enables individuals to spontaneously make decisions on their own when facing an unpredictable reality. Another link can be found in the way TQM cross-functional team members interact to develop new products in the face of changing customer needs, which has similarity with CT's focus on the interaction of organizational variables as a source of influence. Although some authors claim that TQM is contingent on equilibrium and CT on disequilibrium, Stacey contends the tension between the two is necessary. Stacey argues that managers should be effective in both paradigms because organizations exist in a paradox of predictability and unpredictability, certainty and uncertainty [20]. From this view, TQM and CT can co-exist, as they are not mutually exclusive.

2.3. Knowledge management (KM)

KM can be defined as a body of theory involving sharing, creating and applying explicit and tacit knowledge to advance organizational objectives [25]. For the purpose of clarity, explicit knowledge is knowledge made "explicable" and tacit knowledge "is that which has not or cannot be made explicit [26]." Since TQM relies heavily on a codified approach of collecting and disseminating explicit knowledge through formal processes [Limitation 8], it fails to properly consider tacit kinds of knowledge typically shared through experiences, practice, storytelling and informal networks. Hence, adopting a KT approach of tacit knowledge

sharing would allow individuals to acquire "know-how, expertise, experience and savoir faire [27]." Inferred aspects such as these are difficult to acquire through a codified approach because this treats knowledge as an external object that people transfer through purely cognitive means—an underpinning assumption of TQM theory [see limitation 8]. In contrast, a knowledge-as-practice perspective treats knowledge as something interpreted and inseparable from human activity. Thus, by integrating practice-based learning within TQM, employees could develop tacit understandings of work processes. Since inadequate learning has been identified as a common TQM implementation issue [Barrier 7], especially in terms of failing to apply knowledge in practice, adopting practice-based learning could redress this issue.

While tacit knowledge is fundamental to acquiring know-how, Collins asserts three different kinds of tacit knowledge that are seldom differentiated in the literature: "relational, somatic and collective [28]." According to Collins, relational tacit knowledge (RTK) is acquired through human relationships and guidance over an extended period of time—factors that can ameliorate TQM's implementation problem of placing too much emphasis on hard factors [Barrier 4]. On the other hand, somatic tacit knowledge (STK) involves the use of individuals' physical bodies and is more difficult to explicate, since it is derived through demonstration— analogous to practice-based learning. The third kind, collective tacit knowledge (CTK), is a domain of knowledge with a strong resistance to being made explicit, since it involves learning cultural nuances (i.e., savoir faire) that are only acquired by embedding one's self in society. As such, adopting an approach that elicits CTK could enable people to gain increased knowledge of cultural factors, ameliorating the TQM barrier of disregarding contextual factors [Barrier 5].

Another important reason for selecting KM is that its body of theory supports double and triple loop learning, addressing TQM's one-dimensional use of single negative loop learning [Limitation 6]. The problem with single loop learning is that it restricts individuals to correcting actions toward one's goals, whereas double and triple loop learning are reflexive, allowing individuals to critically question their goals and practices, leading to transformation [29].

2.3.1. KM's fit with TQM

According to Zhao and Bryar, some principles of KM have affinity with TQM in respect of the way information is taken as inputs and processed with applied knowledge to produce outputs [30]. Although TQM has been described as more mechanistic than the living system of KM, Zhao and Bryar contend that both theories share principles of empowerment, collaboration, teamwork and customer centricity. Additionally, the KM strategy of "getting the right knowledge to the right people at the right time [27]" could be used to support TQM's aim of continuous improvement and customer satisfaction. Hence, combining KM with TQM could help solve a missing piece of the quality puzzle.

2.4. EALIM's key principles

In conceptual model building, principles provide structure and serve as rules for its operation, creating a paradigmatic boundary in which other constructs can be added. To advance the model building process further, 10 key principles were inductively conceived from the

literature, which reflect the synthesis of EALIM's four organizational theories (CSR, CT, KM and TQM).

1. **Moral anchor:** a Kantian duty ethic that treats people as both the means and the end. This ethic not only reflects CSR's regard for the wellbeing of people and the planet, but also grounds the model in a moral form of capitalism.

2. **Exemplary leadership:** an approach to leading that models service and trust. This approach is epitomized in servant leadership, defined as a way of leading by serving others in the absence of extenuating personal benefits, which empowers followers to become healthier, autonomous individuals. This kind of leadership denotes a CSR approach that encourages wellbeing and links with CT's notion of self-organization.

3. **Boundaryless collaboration:** removing boundaries across disciplines, hierarchies and cultures through effective stakeholder collaboration, which can promote mutual trust and wide organizational support. Collaboration also promotes knowledge sharing and interdependence among stakeholders, prerequisite elements of both CT and KM.

4. **Empowerment and democracy**: devolving power to employees and finding democratic ways of working. The importance of empowerment and democracy cannot be overstated, since numerous studies have found these to be critical for TQM success, factors that also feature in CSR, CT and KM.

5. **Emergence and self-organization:** encouraging new patterns of social order to emerge that allows people to adapt and innovate in the face of change. This CT principle is critical for surviving in a complex environment, and links to KM because it promotes the application of knowledge from learning communities.

6. **Learning communities and team working:** sharing explicit and tacit (relational and collective) knowledge, as well as creating new knowledge to produce innovation. Learning communities are KM groups that are either homogenous (e.g., practitioner-based) or heterogeneous (e.g., intra-disciplinary), and team working is a key factor for successful problem solving in TQM applications.

7. **Practice-based learning:** learning derived in and through practice, which provides both context and experience for learners. From a KM perspective, this kind of experiential learning enables individuals to develop somatic tacit knowledge, resulting in increased know-how and expertise.

8. **Continuous improvement:** incremental improvements to work processes by everyone. Improvement is continuous because it is a never-ending journey of detecting and preventing errors. This TQM principle is critical for nurturing a quality culture, and can also include breakthrough improvements such as redesigning an entire system.

9. **Quality chain:** deems every employee as an internal customer and supplier. This process involves employees obtaining what they need from their internal suppliers, to satisfy the needs of their immediate internal customers. Forming strong quality chains is vital to the success of TQM, as any weak link or error could find its way to the external customer at the end of the chain.

10. **Customer satisfaction:** the end goal of TQM and critical to any organization, for without it, no organization could prosper in a competitive market place. Attaining customer satisfaction requires commitment from all organizational members toward identifying, meeting and reviewing customer needs. This process must involve capturing the voice of the customer through feedback and suggestion schemes.

2.5. EALIM's methods

To implement EALIM, suitable methods need to be selected that can translate its principles into practice. Since numerous methods exist in the organizational literature, those chosen are by no means exhaustive, and neither are they written in stone. Methods can be changed or added to, as long as they fit EALIM's principles and link to any one of its organizational theories.

The methods listed here have been carefully selected to provide a synergetic blend of soft and hard factors. The soft factors reflect the people-oriented elements of organizational culture, i.e., leadership, people and communicative interaction, while hard factors relate to the analytical and technical processes people use. Selecting the right blend is important because various authors claim a balance of soft and hard factors produce a higher probability of success [31, 32]. Fotopoulos and Psomas go further on this point by asserting successful quality improvement efforts are more influenced by soft factors than hard [33]. Accordingly, most of the following methods are expressive of soft factors, capable of advancing EALIM's principles.

2.5.1. CSR methods

Shared vision: a CSR vision that is commonly shared by stakeholders, as opposed to one imposed by management. This could create social legitimacy and enable employees to realize the impact of their personal work beyond the organization's primary task.

Stakeholder approach: the crossing of boundaries between internal and external stakeholders through collaboration in order to create mutual trust and wide organizational support.

Corporate philanthropy: discretionary cash contributions direct to charities and social causes, which can build strong community relations, motivate the workforce and significantly enhance people's quality of life.

Community volunteering: empowering employees to volunteer their time and talents toward social causes, for the purpose of integrating with community organizations and effect positive change in the world.

Socially responsible business practices: support of human and ecological sustainability in order to protect the wellbeing of employees and the environment.

2.5.2. CT methods

Complexity mental model: the adoption of a mental model that welcomes disorder as a partner, uses instability positively, sees change as a necessity and understands that complexity is unavoidable.

Planned strategy: a long-term business strategy that enables stable and incremental change with clear goals designed to advance the organizations primary task.

Emergent strategy: spontaneous strategies of a novel kind that allow the organization to self-organize, adapt to uncertainty, and engage in revolutionary change.

Ordinary management: the deployment of rational, formal and analytical management methods within a constant shared paradigm, i.e., single loop learning.

Extraordinary management: the use of creative, informal and intuitive management methods that alter the shared paradigm, i.e., double loop learning.

2.5.3. KM methods

Triple loop learning: single, double and triple loop learning that allows individuals and groups to engage in (1) improvement, by learning new ways of doing, (2) reflection, by learning new ways of thinking, and (3) transformation, by learning new ways of learning.

Communities of practice: practitioner-based (homogenous) groups for mutual support, knowledge sharing, and learning of best practices.

Project teams: intra-disciplinary (heterogeneous) teams for specific projects, problem solving, knowledge creation and building innovation.

Storytelling and narratives: the use of storytelling and narratives among organizational members for the purpose of creating identity, deep meaning and tacit knowledge sharing.

Knowledge brokers/boundary spanning: organizational members who act as sources and facilitators of knowledge, due to their interaction with different communities of knowledge and discipline.

2.5.4. TQM methods

Voice of the customer: the continuous monitoring of dynamic customer requirements, so changes can be rapidly identified in order to avoid customer dissatisfaction and market drift.

Force field analysis: the identification of factors that block movement toward a goal, i.e., restraining forces, and factors that support movement toward a goal or solution, i.e., driving forces.

Nominal group technique: a democratic technique for acquiring group ideas for the detection and correction of errors.

Affinity diagram: the collaborative arrangement of a large number of ideas into groups for review and analysis, to stimulate creative improvement.

Pareto principle: data analysis of the vital few and the useful many, which helps identify the biggest problems to solve.

2.6. EALIM's conceptual framework

The conflation of EALIM's four organizational theories, 10 principles and methods, form a coherent conceptual framework as illustrated in **Figure 1**. The framework's permeable boundary has two meanings: first, it symbolizes the removal of barriers to teamwork through collaboration and second, it represents the boundaryless connection and reciprocal flow of influence between an organization and its external environment. The dynamics between these two domains emerge from two types of feedback loops: negative (self-correcting) loops that balance change and positive (self-reinforcing) loops that amplify change. The bi-directional
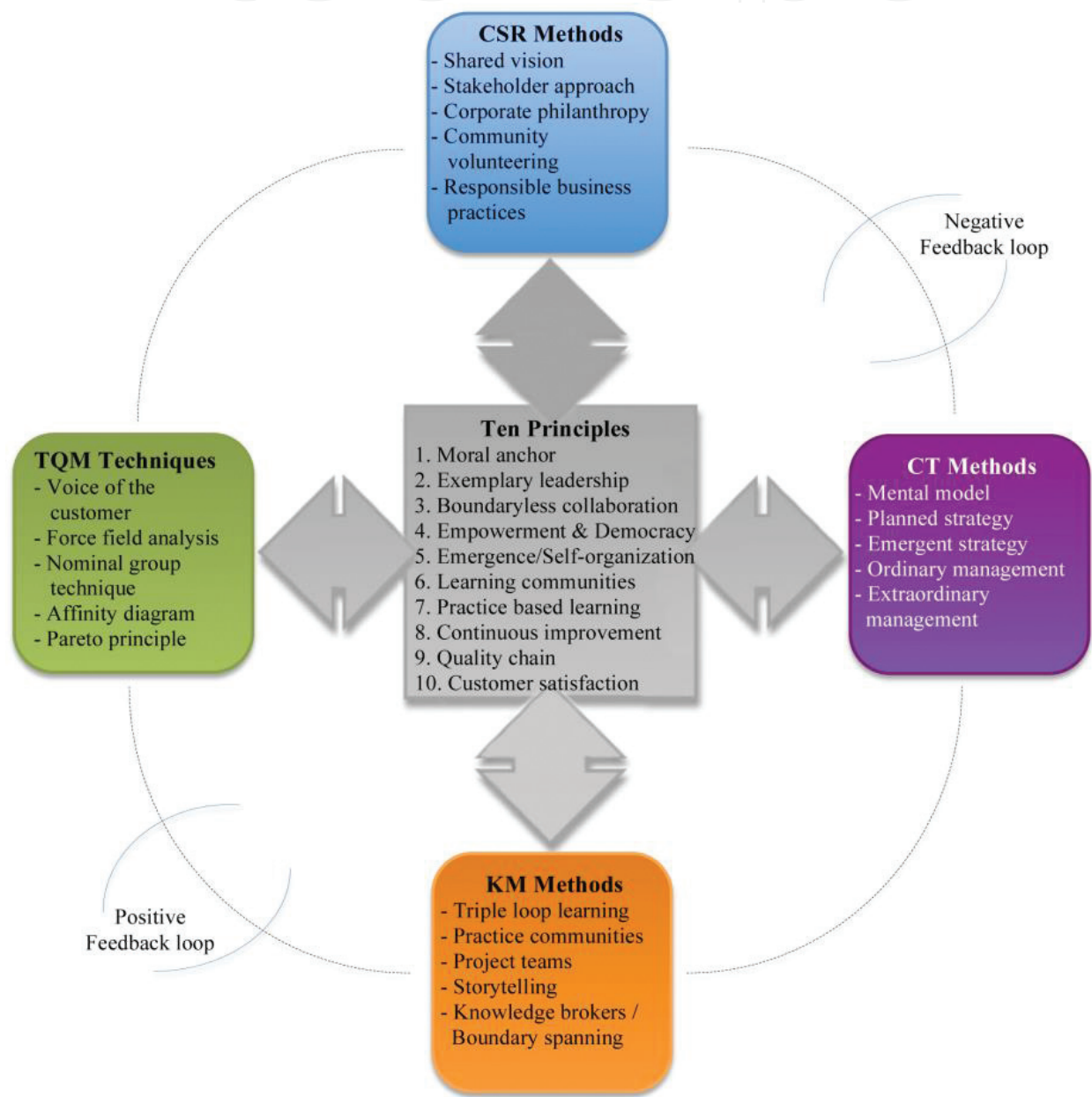

CSR Methods
- Shared vision
- Stakeholder approach
- Corporate philanthropy
- Community
  volunteering
- Responsible business
  practices

Negative
Feedback loop

TQM Techniques
- Voice of the
  customer
- Force field analysis
- Nominal group
  technique
- Affinity diagram
- Pareto principle

Ten Principles
1. Moral anchor
2. Exemplary leadership
3. Boundaryless collaboration
4. Empowerment & Democracy
5. Emergence/Self-organization
6. Learning communities
7. Practice based learning
8. Continuous improvement
9. Quality chain
10. Customer satisfaction

CT Methods
- Mental model
- Planned strategy
- Emergent strategy
- Ordinary management
- Extraordinary
  management

Positive
Feedback loop

KM Methods
- Triple loop learning
- Practice communities
- Project teams
- Storytelling
- Knowledge brokers /
  Boundary spanning

Figure 1. Conceptual framework of EALIM.

arrows between the 10 tenets and 4 theories connote how they shape and are shaped by each other, allowing the model to adapt reflexively.

2.7. Advantages of EALIM's conceptual framework for theory

Although authors have examined conceptual links between TQM and CSR, TQM and CT, and between TQM and KM, no other authors have fully integrated all four of these organizational theories into one coherent conceptual TQM framework. On this basis, EALIM can be regarded as a novel contribution to TQM theory. As previously discussed, integrating CSR, CT and KM with TQM present advantages that address TQM's theoretical limitations. **Table 3** presents a summary of these limitations and the elements of EALIM that hold advantage over them.

Conventional TQM	EALIM
Investment and consumer capitalism	Moral capitalism
Formal rationality	Substantive rationality
Utilitarian rationality	Kantian rationality
Executive vision	Shared vision
Technocratic ideology	Humane ideology
Single loop learning	Triple loop learning
Newtonian paradigm	Complexity paradigm
Codified and explicit knowledge sharing	Explicit and tacit knowledge sharing
External customer focus	Stakeholder focus

Table 3. Limitations of conventional TQM addressed by EALIM.

3. Implementation of EALIM

The target organization used to implement EALIM employed 270 people and provided care services to 74 patients. The fieldwork involved 91 participants spread across 10 hospitals and care homes. The structure within the organization consisted of top managers (executives), middle managers (hospital and care home managers), staff nurses, care workers and a multi-disciplinary clinical team. Participants were selected from different disciplines and hierarchical positions using non-probability sampling techniques (i.e., opportunistic, convenience and snowballing): techniques congruent with participatory research [34]. The broad selection of participants allowed insights into the divergent perceptions and experiences of organizational members, and to generate a broad in-depth analysis of organizational culture. In terms of participant's ethnicity, 46% were white British, 32% were black African, and the others were composed equally between Asian and black Caribbean. The largest age group was 22–29 (37%), while the 30–39 and 40–49 age groups made up 29 and 24%, respectively. The remaining participants fell into the 50 and above category.

Data were generated between July 2011 and January 2013 in three AR cycles. The first cycle involved gathering data for 4 months prior to the adoption of EALIM and was critical for developing a baseline assessment of the organization, as well as constructing a collaborative action plan with top management. In the second cycle, EALIM was implemented over a 12-month period and data were gathered with a focus on examining participants' acceptance and resistance to its interventions, along with its impact on organizational improvement, if any. In the third cycle, data were gathered over a final 3-month period and findings were evaluated against the baseline assessment from the first cycle. This allowed me to identify the overall impact EALIM had on organizational culture and improvement.

As previously stated, the methods used to gather data included depth interviews, participant observation and focus groups. Depth interviews were generally informal and involved open questions with a low degree of structure to allow participants the liberty to talk about what is important to them. A total of 45 participants were interviewed of differing rank, discipline, location, gender, age, ethnicity and length of service. Although my selection of interview participants was not a proportional reflection of the population, it nevertheless produced an illustrative profile that included a diversity of participants from management and non-management positions.

Participant observations involved prolonged periods of social interaction with the researched, and included board meetings, informal and formal discussions, luncheons, and EALIM seminars. The idea is to study participants' everyday experiences, thinking and actions, which may include talking to them about their feelings and interpretations. The total number of observational cases selected from fieldwork notes and transcripts amounted to 37 entries. The author's level of participation ranged from a total researcher—full observation without participation in the flow of events, to a total participant—completely involved in activities.

On the other hand, focus groups were used to collectively generate future action and gain insights into the divergent views of participants. A total of eight groups were held during EALIM's implementation, with an average of five participants in attendance in each group. While an interested volunteer group of snowball participants attended, top and middle managers were invited with the intention of forming a strong political alliance toward EALIM's adoption. In fact, many of the ideas for EALIM's adoption came from focus group participants, a feature that became a success factor for EALIM's implementation. Another success factor was the commitment of senior executives, of whom several consistently attended focus groups and actively implemented agreed action plans. This finding supports many other studies showing top management commitment is a key factor for TQM success. The following sub-headings setout the key research findings as a result of EALIM's implementation.

3.1. Increased moral perception of the organization

During EALIM's implementation, executives agreed to fund the construction of an orphanage in India and publicize the project to its employees. During interviews, when participants were asked about their views on the company's philanthropy in India, most middle managers and frontline staff implied the India project had increased employees' moral perception of their employer. Their responses include "People need to know the company is not just about shareholder wealth," "They are doing a good job helping the ones in need … it changed my

perspective of [the organization]," "Giving back to society is such an important aspect of the company," and "The company is not profit orientated and willing to give back." These responses suggest that because employees identified their employer's philanthropy as a moral ideal, they perceived their employer to be moral. This organizational perception is a significant improvement from that identified in the first cycle, when employees held the view that the company valued profit more than staff.

3.2. Increased organizational commitment

Corporate philanthropy under EALIM had generated greater organizational commitment among employees. For example, during an interview one middle manager claimed, "One staff was moaning about her wages, but after realising what the company was doing in India, she wanted to volunteer her pay rise to help projects like this." This middle manager's claim was consistent with comments from most frontline staff, particularly care workers. For instance, when care workers were asked what they thought of the India project, their responses include "It changed me. Nothing will make me leave … I appreciate the work this company does," "It made me feel good and inspired me to work more so they can support the countries outside" and "It drew me to the company." Compared with the low care worker commitment found in cycle one, these responses indicated an increase in organizational commitment and that corporate philanthropy inspired motivations to act toward the good of the organization.

3.3. Emergence of a learning culture

Under EALIM, an initiative called microteaching was introduced to promote the principle of practice-based learning. Spawned from a focus group participant, this initiative involved clinicians' role modeling, observing, and providing feedback to employees during their shifts. Instead of relying on classroom training courses, this initiative focused on increasing the knowledge of staff in practice through a question and answer approach during the shift.

Participant responses indicated that a learning culture had emerged as a result of microteaching. Interview responses from top and middle managers that support this finding include "There is a lot more emphasis on learning," "The culture allows for people to learn from their own desire and effort," and "There's now a theme of learning in the organization." The perception of a learning culture was shared by focus group participants, who gave insights as to why they thought a learning culture had emerged. These include "Learning in the organisation has increased because we are microteaching on the unit and staff make a proactive effort to develop their knowledge … it's certainly changed the culture," "Staff are asking more detailed questions," and "What I've observed is staff get to see the people that deliver the training around the units and ask them questions about this or that during the shift." These responses suggest an increased commitment to learn was stimulated by meaningful interaction between educators and employees, who found practice-based learning more relevant to their learning needs than classroom training courses.

Interview responses from care workers appeared to support the views of focus group participants. These include "Microteaching is helpful…they [trainers] show us how to do the MDT notes and complete incident reports," "Trainers show us how to look after clients" and "Local

training is more specific to clients." These responses indicated the use of practice-based training had created greater tacit knowledge among employees.

3.4. Improved patient self-advocacy

During a focus group at the start of EALIM's implementation, participants were asked to share ideas on how EALIM's principles could be adopted in the organization. An idea shared by the chief operating officer (COO), was to launch the use of community groups. He described them as 20-min daily morning meetings that could take place in the main communal area of hospitals and care homes, so local patients and staff could collectively discuss ideas and agree "what's going to happen for the day." He stated that community groups could "…bring the important decision-making of the unit to staff and patients, rather than the typical hierarchy of management." His idea resonated with EALIM principles of empowerment and democracy, emergence and self-organization, as well as learning communities and team working. The following month, the COO reported that community groups were implemented.

Three months later, the use of community groups was reviewed during a focus group. In that discussion, a director described being "really surprised" after he attended a community group the previous day, where he observed a patient who instead of "normally sitting in the background without saying much," was "quite assertive about what she wanted to do." A care worker who attended the focus group also added, "This morning one of the patients chaired the community meeting…you can really see it's boosting her esteem really. It was just nice that she could sort of have the conversation with her fellow service users and speak to them, because usually she's quite intimidating to the others and for her to be able to talk to them reasonably rather than shouting was really encouraging." According to these empirical accounts, patients' participation in community groups enabled greater confidence in their self-advocacy and more meaningful interaction with others.

3.5. Improved patient independence

Interview responses also indicated an increase in patient independence. One middle manager claimed, "Before EALIM was introduced, we were making the decisions and the focus was on nursing, instead of creating independence. What we now do is let people [patients] do things for themselves." Her claim was consistent with responses from several care workers, such as "…before, we had a different approach. It was like our job was to babysit clients as opposed to now, where it's more therapeutic," "Staff are working more to help patients as opposed to keeping them" and "The care approach has changed from care-taking patients, to helping them become independent." These kinds of responses support the finding that EALIM's adoption contributed to an improvement in patient independence.

Several participants also implied community groups played a role in improving patient independence. Two care workers remarked, "In community meetings, we'll ask clients what they need" and "Community meetings involve patients in making decisions," while one middle manager claimed, "We do community meetings daily. The difference it's making is patients are more involved in making choices and planning their activities."

3.6. Poor leadership was a barrier to consistent service quality

Although there had been organizational improvements during EALIM's adoption, several top managers stated that there were inconsistencies in service quality because of poor leadership. For example, one top manager stated, "There are inconsistencies across the units because of the way managers lead, especially at [hospital X]. When I'm on call, the majority of calls are from there." This view was supported by another top manager who stated, "EALIM has been welcomed by everyone but it hasn't been successfully implemented at [hospital X]."

Interview responses from care workers at hospital X supported the view from top managers. When care workers were asked to describe their experience of the way their manager leads, their responses include, there are problems here, clients are ignored and people don't feel safe. If a person pulls the alarm it could take five minutes for somebody to come…when I first joined [two months ago] I was told I would meet with the manager every month, but that hasn't happened, and "I feel there is no leadership here, someone needs to say 'this is what's going to happen'." These accounts suggest the manager's lack of clear leadership and visible commitment was detrimental to the wellbeing of patients and staff.

4. Conclusion

The development of EALIM presents an evolutionary step in TQM theory. While it possesses theoretical features congruent with TQM, it goes beyond its paradigmatic boundaries by adopting divergent organizational perspectives. Rather than build a new model by comparatively analyzing extant TQM frameworks, the eclectic model building approach used here proved useful in two ways. First, it provides different organizational perspectives without annulling each other, achieved by identifying distinct viewpoints from each theory while highlighting their interrelatedness with TQM. Second, the interplay between these organizational theories offers different perspectives that enable a broader understanding of organizational processes, since any one theory only offers a restricted view of a complex phenomenon.

The synthesis of EALIM's four organizational theories makes explicit links between theoretical constructs that are excluded from other TQM models. As such, EALIM's development is a move toward a more complete gestalt of quality improvement theory. In addition to making a theoretical contribution to TQM, this model holds the prospect of increased success toward organizational improvement, since it is better suited to a postmodern organizational milieu. Although other QI models include CSR principles (e.g., EFQM, Baldrige) within their frameworks, EALIM's integration of a Kantian ethic presents a step further, in that it forms a novel moral anchor that binds organizational members to altruistic decision-making and behavior. Not only does this moral anchor connect stakeholders to a social ideal judged as intrinsically good, but also forms the basis for promoting a moral kind of capitalism, epitomizing the next stage in the evolution of quality.

Research findings from EALIM's implementation reveal its capability to achieve organizational transformation, evidenced by the development of a moral organizational perception, increased organizational commitment, and the emergence of a learning culture. Various authors agree that learning organizations hold advantages, which include increased innovation, sustainability and competitiveness [35, 36]. A prerequisite for promoting a learning culture was the adoption of practice-based learning, which holds greater potential for human development than codified and explicit knowledge sharing. Practice-based learning also had a positive impact on employee commitment to learn, a finding noticeably absent from the TQM literature, perhaps because TQM theorists do not commonly advocate practice-based learning.

The finding that EALIM's adoption improved patient self-advocacy is also novel since a search of the literature yielded no evidence of this from any quality improvement initiative. This finding is particularly important for patients with a learning disability or mental illness because they typically lack opportunities to contribute to their own lives and shape the service they receive. From this perspective, this finding demonstrates an essential element of research quality: namely, "quality as engaging in significant work [37]."

Improved self-advocacy and independence among patients show a direct improvement in patient care. Since most TQM healthcare studies do not indicate a direct improvement to patient care, this study demonstrates an original contribution to TQM practice. Despite these improvements, inconsistencies existed in local services due to poor local leadership. However, some inconsistencies among local services are to be expected, especially since services are prone to variability because of their heterogeneous nature [38]. On this basis, the commitment of all internal stakeholders would be required to achieve sustainable service quality.

4.1. Limitations and implications for future research

A limitation of this study is that its findings should not be generalized across all healthcare sectors, as each environment is bound by its own contextual factors. Nonetheless, in contexts where there is wide commitment to EALIM's principles, the results of this study could be replicated. Researchers may wish to take this study further by examining EALIM's applicability in contexts outside of healthcare, especially where ethics are at the fore (e.g., financial services). Alternatively, others may wish to use this research to explore various themes, such as the adoption of complexity perspectives in management, or the use of practice-based learning. Furthermore, EALIM could be of particular interest to managers working in environments with a high degree of disequilibrium (e.g., capital markets) or innovation (e.g., technology industries), because its CT and KM methods promote emergence in the face of instability, and knowledge creation in highly competitive markets.

As a final point, decision makers wishing to adopt EALIM should be aware of what it is they are committing to and what barriers they may encounter. To avoid inconsistency between the message and practice of EALIM, top managers are recommended to not only espouse EALIM's principles, but also particularize them in their everyday work with others: thus providing a personal exemplar of action. As William Shakespeare wrote in Coriolanus, "Action is eloquence, and the eyes of the ignorant more learned than the ears [39]."

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